Admission Handbook & Placement Agreement

House of Hope for Girls Program

House of Hope for Girls Program
Referral Form

House of Hope for Girls is our residential program serving girls 12-17 who are survivors of Domestic Minor Sex Trafficking. The program offers a continuum of care including therapy, education, and life skills classes, designed to foster holistic change in the life of each survivor.

THE DEFINITION OF DMST: is the commercial sexual exploitation of American children within U.S. borders. It is the "recruitment, harboring, transportation, provision, or obtaining of a person for the purpose of a commercial sex act" where the person is a U.S. citizen or lawful permanent resident under the age of 18 years.

Applicant's Name: ________________________________DOB: ____________________

Contact Person: __________________________________ Phone: ___________________

Contact Email: ____

Applicant,

Thank you for your inquiry into House of Hope for Girls Program. In order for us to make a decision for admission please provide the following information:

- All psychological/psychiatric exams, reports, recommendations
- All legal documents (probation orders, charges, custody papers, social security card, birth certificate)
- All medical documentation (shot records, dental records, most recent physical exam, etc.)
- School records

All necessary documentation must be received and reviewed by the House of Hope Clinical Team before a determination will be made if our agency is a suitable program for the applicant's needs.

House of Hope for Girls Program Admission Application

House of Hope exists to confront the issues of childhood sexual abuse and exploitation through awareness, training and treatment programs for girls and women.

All services are provided without regard for race, sex, creed, religion, or national origin.

Participant's Name:

____

Last First Middle

Home Address:

____

Street City County, State Zip

Date of Birth: ______________________ Social Security Number: _____-_____-_______
Month / Day / Year

Race ______________________________

Type of Insurance: ______________________ Insurance Policy Number: __________________

Height ________ Weight ____________ Eye Color _________ Hair Color ___________

Guardian/DFCS Case Manager: ____

Work Phone: ________________________________

Mobile Phone: _______________________________

Address:
____

Email: ____

DFCS County: ________________

DFCS Supervisor Name: ____

DFCS Supervisor Phone Number: ____
DFCS Supervisor Email: ____

Is the youth currently on probation? ☐ Yes ☐ No

Name of the court service worker or probation officer:
____

Phone Number: ____

Email Address: ____

County: ____________________

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Please list any important events in your life that may relate to this problem(s):

Has the youth had counseling/therapy in the past? ☐ Yes ☐ No

If yes, where _________________ When? ____________________________________

Indicate any of the following that apply to the youth:

` Current ___________ Past _______ Thoughts of suicide
` Current ___________ Past _______ Plans for suicide Attempt
` Current ___________ Past _______ Hurting yourself deliberately
` Current ___________ Past _______ Thoughts of hurting someone else

` Has the youth suffered any loss or separation in the past 12 months? YES ___ NO____

Education History

Current school attending: ____

Address of current school: ____

What is youth's current grade placement? _________

Does the youth have an IEP or 504 plan? ☐ Yes ☐ No

Any problems learning to read? Yes_____ No _____
Any problems learning to do math? Yes _____ No _____
Ever enrolled in special education? Yes _____ No _____

Health

List any current health problems for which youth is receiving treatment:

`

List currently prescribed medications:

`

List any over the counter medications:

`

Who is youth's current Doctor? ________________________

When did youth last see a doctor? _____________________

Does the youth have any known allergies? ☐ Yes ☐ No

If "yes," list allergies:_

If yes, please provide a copy of this with the latest transcripts.

Additional Family/Youth Information

Please describe the youth's strengths:

Briefly state your goals for your youth:

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Briefly give a history of youth's exploitation history:

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Four Things You Should Know

A medical examination by a physician will be required as a part of the placement process. Financial arrangements will be discussed during the application process and finalized at the time of placement.

30 days of medication should be provided on the date of intake.

All youth are accepted on a 30-day assessment basis. Based on information gathered during this assessment House of Hope Clinical team will make an acceptance decision.

If emergency placements do not meet the criteria for sexual exploration, they will be given a discharge notification.

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________________________________ __________________

Signature of Legal Custody Holder Date

____

Printed Name of Legal Custody Holder

BOTTOM OF FORM

HOUSE OF HOPE FOR GIRLS PROGRAM

Social History
Please check all that apply to applicant – current or past.

☐ Has leadership ability
☐ Poor hygiene
☐ Bullies others
☐ Walks in sleep
☐ Does not sleep well
☐ Shows off
☐ Shares
☐ Does not eat well
☐ Is considerate of others
☐ Temper tantrums
☐ Lying
☐ Fire setting
☐ Fighting
☐ Complains others don't like her
☐ Sucks thumb
☐ Is very jealous
☐ Is self-confident
☐ Enuresis (wets bed/clothes)
☐ Encopresis (soils bed/clothes)
☐ Is suspicious
☐ Has many sudden mood changes
☐ Is very lazy
☐ Is nervous
☐ Is abusive to self
☐ Is abusive to animals
☐ Is abusive to smaller children
☐ Is abusive to others
☐ Suicidal thoughts
☐ Suicidal gestures
☐ Has been sexually abused
☐ Sexually abusive to others
☐ Sexually active
☐ Runaway behavior
☐ Has been in trouble with police
☐ Disrespect of authority
☐ Vandalism
☐ Speech disorder
☐ Hearing impairment
☐ Is easily discouraged
☐ Tobacco use
☐ Is depressed
☐ Alcohol use
☐ Marijuana use
☐ Other illicit drug use
☐ Inhalants
☐ Has strong hates
☐ Has unusual fears
☐ Follows directions well
☐ Is overly dependent for age
☐ Is generally happy
☐ Holds grudges
☐ Is overactive
☐ Controls temper
☐ Has nightmares
☐ Is creative
☐ Daydreams a lot
☐ Is affectionate
☐ Withdrawn
☐ Low self-esteem
☐ Is very shy
☐ Is very stubborn
☐ Is disobedient
☐ Profanity
☐ Is very sensitive
☐ Steals
☐ Has a short attention span
☐ Is destructive
☐ Is sociable
☐ Promiscuity
☐ School work refusal
☐ Truancy
☐ Anorexia (eating disorder)
☐ Bulimia (eating disorder)
☐ Seizures
☐ Anxiety attacks
☐ Vision impairment

Explain and give examples of all items checked in section above (Social History): Attach additional paper if extra room is needed.

General Notice and Release

The undersigned, being the legal Custodian and Guardian of ______________________ who has been placed at the House of Hope for Girls Program (hereinafter referred to as the "Program"), and the undersigned youth, have been informed that the Program does not use chemical or mechanical restraints. However, when absolutely necessary, we are trained and certified to perform therapeutic holds (using the MindSet approach) to prevent a participant from causing physical harm to themselves or others. If it is necessary to perform a therapeutic hold on a participant it is highly likely that that participant will have escalated to a point where they will need a higher level of structure than the Program can safely provide and the participant could be transferred to a psychiatric hospital for evaluation, if deemed necessary by the treatment team. The undersigned have been informed that the Program is not, and will not, be the legal custodian and/or guardian of the participant and that the Program is not responsible for actions taken by the participant either while on or off the Program property. Furthermore, the undersigned have been informed that if the participant runs away from Program property or runs away while off Program property, the Program will call the local police department and will notify the undersigned Legal Custodian and/or Guardian. However, the Program will take no action to secure the return of the participant to the Program. The undersigned Guardian or Custodian must take action to return the participant to the Program.

Legal Custodian/Guardian Printed Name ____________________________________

Legal Custodian/Guardian Signature_______________________________Date___________

Participant Printed Name ____

Participant Signature____ Date___________

Receipt of Information Form

I, ____, custodian of _______________________, have been provided information about the House of Hope for Girls Program services, environment, age ranges and behavioral characteristics of other participants in the program. I have considered this information provided and have determined that the environment is appropriate and does not represent an undue risk to the health and safety of _____________________________________.

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Custodian Signature_______________________________ Date______________

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Custodian Printed Name____

`

Staff Signature___________________________________ Date______________

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Staff Printed Name/Title ____

Confidentiality Waiver and Acknowledgment

I, the undersigned, understand that approved safe contact visitors, volunteers, or House of Hope Board Members may visit the House of Hope residential site. These visitors will complete a confidentiality waiver and acknowledge that all information at the House of Hope programs is confidential. These visitors will not disclose any confidential information pertaining to the House of Hope programs. This will include, but is not limited to, all of the discussions related to participants, location of facilities, and all other information obtained while on site at this program.

Participant Name Printed: ________________________________

Participant Signature: ________________________________ Date: ____________

Parent/Guardian Name Printed: _________________________

Parent/Guardian Signature: ___________________________ Date: ______________

Receipt of Privacy Practice Information

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting House of Hope for Girls Program at 1040 Boulevard SE, Suite M, Atlanta, GA 30312 or (470) 344-4905.

By signing below, you acknowledge that you have received a copy of our Notice of Privacy Practices on the date indicated below.

Legal Custodian/Guardian Signature______________________ Date___________

Legal Custodian/Guardian Name (Printed)_____________________________

Participant Signature____________________________ Date_____________

Participant Name (Printed)____

Consent to Services

I, ____voluntarily request services for individual and family or other related concerns from House of Hope Programs. I/We have read and had the opportunity to discuss the Handbook and other program documents and request services/counseling in accordance with these guidelines.

Print Client Name____________________________

Client Signature___________________________ Date____________

Staff Printed Name____

Witness: Staff Signature/Title____________________________ Date________

I attest that I am the legal custodian of the above-named child and am authorized to seek services/treatment on their behalf.

Custodian Print Name____

Custodian Signature________________________ Date_____________

Witness: Staff Signature/Title __________________ _______ Date__________

Consent for Medical and Dental Services

I hereby authorize House of Hope for Girls to obtain medical, dental, and psychiatric care for ____
as required or medically necessary. I understand that this could include routine and emergency medical and dental examinations, medication management (as prescribed by a physician or psychiatrist), testing, and possible hospitalization. I hereby authorize and consent to any X-ray examination, cleanings, anesthetic, inoculation, vaccination, medical or surgical diagnosis, treatment, and hospital care to be rendered to ____
while placed at House of Hope Girls Residential Program, under general supervision and upon the advice of a physician, psychiatrist, or dental care provider licensed under the provisions of the Medical Practice Act in the State of Georgia.

I also hereby authorize any insurance benefits to be paid directly to any hospital or doctor providing care, and I recognize my responsibility to pay for all non-covered services. In addition, I authorize the physician to release any information necessary to process an insurance claim.

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Legal Custodian/ Guardian Signature__________________________Date_____________

Informed Consent for Treatment with Psychotropic Medications

I, ___________________________________, am currently a patient of Dr.____________________ and am receiving care at House of Hope for Girls Program. My doctor has recommended that I receive a psychotropic medication, ____, to assist in my treatment. This medication is classified as a ____________________________and is used in the treatment of ____.
I have been given an opportunity to discuss the risks and benefits of the medication treatment, common medication side effects and alternative treatments.
I agree to take the medication as prescribed, report any and all side effects and concerns about the medication promptly to my doctor, nurse, or program staff and to seek out additional information and ask questions so that I can remain an informed patient.
I agree to not give my medication to any other participant and understand that it is solely prescribed to me and for my treatment alone.
I understand that I am taking this medication voluntarily unless my doctor feels that an emergency is at hand and any delay in receiving the medication could likely result in harm to myself, those around me or tot property. I further understand that I may speak directly with the doctor treating me regarding my medication if I have any questions or concerns. I also understand that this medication is designed to help me but that no guarantees of successful results can be made.
On this basis, I am making an informed consent to take this medication as prescribed and agree to allow my doctor, his or her designee or the residential staff to administer the medication to me as ordered by my physician.

___________________________	___________________________	____________________
Participant (print)	Participant (signature)	Date
___________________________	___________________________	____________________
Parent/Guardian (print)	Parent/Guardian (signature)	Date

Verbal Permission obtained from (Parent/Guardian) _

___________________________	___________________________	____________________
Staff (print)	Staff (signature)	Date
___________________________	___________________________	____________________
Staff (print)	Staff (signature)	Date
___________________________	___________________________	____________________
Physician (print)	Physician (signature)	Date

Hair Treatment Consent Form

I, ____, hereby give consent for ____________________________________, to get her hair cut, colored/highlighted, or treated (this includes sew-in, glue-in, or braided extensions). I understand that I will be informed in advance of any major changes to current hairstyle. By consenting to these hairstyle changes, House of Hope will not be held responsible for any damages or unsatisfactory work done to the client's hair or personal appearance. If, for any reason, the participant is dissatisfied with the treatment, she can request a grievance form and/or she can request for the stylist to come at her earliest convenience to make any corrections or alterations.
I understand that House of Hope will only allow licensed cosmetologists to perform haircuts, coloring/highlighting, or chemical hair treatments of any kind.

Printed Name of Participant __________________________ Date ________________

Signature of Participant __________________________________ Date ________________

Printed Name of Parent/Custody Holder ____

Date ___________________________

HOUSE OF HOPE FOR GIRLS PROGRAM

Supplemental Medical Information
(Required prior to placement)

Youth and Family Health History

Name of Youth ___________________________________ Sex _______Date of Birth _________

Which of the following diseases has the child had? (Please give dates)

Mumps	Whooping Cough	Measles
Pneumonia	Heart Trouble	Tuberculosis
Diabetes	Sickle Cell	Convulsions
Polio	Rheumatic Fever	Chicken Pox
Asthma	Scarlet Fever	Other

Give dates and nature of any serious injuries and/or hospitalizations:

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`

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Date of Last Dental Appointment ___________________________
Date of Last Medical Appointment __________________________

Name of Dentist ____
Name of Doctor ____

Address of Dentist ____

Address of Doctor ____

Hospitalization of immediate family members for injury or illness (including physical and emotional):

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`

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Completed by (print):______________________________Relationship: ______________

Signature: ______________________________ Date: _______________

Authorization to Release/Obtain Information

PARTICIPANT'S NAME: ____
DATE OF BIRTH: ____/ ____ / ________
(Please print)

I hereby authorize House of Hope (see specific person/program below):

PROGRAM NAME: House of Hope Girls Program
ADDRESS: P O Box 21283, St Simons Island, GA 31522
TELEPHONE NUMBER: (912) 571-4378

_To release the following protected information to:
AND/OR
_To obtain the following protected information from:

PERSON or AGENCY NAME: ____
ADDRESS:____
____
TELEPHONE NUMBER: ____

The protected health information authorized to be obtained/used or disclosed includes:

Demographic information of client, medical records, psychological evaluations, medication records, treatment plans, admissions packet, health insurance information, placement into House of Hope's Girls Residential Program, any transition/discharge plans.

The protected health information is to be obtained/used or disclosed for the purpose of: Coordination and continuation of care of the referred client.

RESTRICTIONS (please tell us what you would *not* like given out):

This Authorization is in effect until:

_the period necessary to complete all transactions on matters related to services provided to me.
_one year from the date this form is signed ____/ ____ / _______

I understand that the federal Privacy Rule (HIPAA) does not protect the privacy of information redisclosed, and, therefore, request that all information obtained from this person or agency be held strictly confidential and not be further released. I further understand that my eligibility for benefits, treatment or payment is not conditioned upon my provision of this authorization.
I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand I have the right to revoke this authorization, in writing, at any time.

Signature of Applicant/Guardian/Participant________________________________Date: ______

Signature of Witness/Title____ Date: _________

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Use this space only if individual withdraws authorization

Date authorization is withdrawn_______________ Signature of Individual___________________________

Printed name of Individual _______________________________

Reason for withdrawal:

HOUSE OF HOPE FOR GIRLS PROGRAM

Participant Safe Contact List

Participant's Name: ____

#1
Name: ______________________________ Phone Number: _________________________

Relationship: _________________________ Please check the type of contact permitted: ▢
Phone ▢
Letter ▢
In-Person ▢

Should permitted types of contact be supervised? ▢ Yes ▢ No ▢ Other: _

#2.
Name: ______________________________ Phone Number: _________________________

Relationship: _________________________ Please check the type of contact permitted: ▢
Phone ▢
Letter ▢
In-Person ▢

Should permitted types of contact be supervised? ▢ Yes ▢ No ▢ Other: _

#3.
Name: ______________________________ Phone Number: _________________________

Relationship: _________________________ Please check the type of contact permitted: ▢
Phone ▢
Letter ▢
In-Person ▢

Should permitted types of contact be supervised? ▢ Yes ▢ No ▢ Other: _

#4.
Name: ______________________________ Phone Number: _________________________

Relationship: _________________________ Please check the type of contact permitted: ▢
Phone ▢
Letter ▢
In-Person ▢

Should permitted types of contact be supervised? ▢ Yes ▢ No ▢ Other: _

Please note, only contacts approved in writing by guardian will be allowed to communicate with participant. Please notify case managers of any changes or updates to approved list.